

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

July 7, 2015

Ms. Tara Graham, Administrator
Arbors
687 Harbor Road
Shelburne, VT 05482-7698

Dear Ms. Graham:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 9, 2015**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2015
NAME OF PROVIDER OR SUPPLIER ARBORS		STREET ADDRESS, CITY, STATE, ZIP CODE 687 HARBOR ROAD SHELBURNE, VT 05482		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site investigation of a facility self-report was conducted on 6/8/15 and 6/9/15. The following regulatory violation was identified related to the self-report.	R100		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the home failed to assure that care plans reflected the current care needs and services necessary to assure comfort and safety for 3 of 4 residents reviewed. (Residents #1, #2 and #4). Findings include: 1. Per record review the care plan for Resident #1, whose most recent assessment of 12/17/14 indicated the resident was totally dependent on staff for all ADLs (Activities of Daily Living) including mobility both in and out of bed, did not address a recent fall or interventions to prevent further falls. A nurse's note, dated 5/25/15, indicated a "....fall from bed onto mat found on right side.....laceration on right occipital area with hematoma present..." Per interview with staff members who had provided care to the resident on 5/25/15, prior to the fall, RCA (Resident Care Associate) #1 had positioned the resident in bed	R145	Actions to correct deficiency: • Resident #1 no longer resides at the Arbors. • Resident #2 – Care plan and kardex updated to reflect current needs and services. • Resident #4 – Care plan and kardex updated to reflect current needs and services. • Complete audit performed to ensure that care plans and kardex reflect current needs and services.	6/9/15 6/9/15 6/16/15

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6699

ZTK411

If continuation sheet 1 of 3

R145 POC accepted 7/7/15 BHWERN/PMC

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R145	Continued From page 1 at approximately 2:00 PM and RCA #5 indicated that s/he had observed the resident lying on his/her left side at approximately 3:30 PM. Although the LPN (Licensed Practical Nurse) responsible for administration of medications had found the resident lying on the mat on the floor at approximately 4:00 PM, staff were unable to determine how the fall had occurred. Despite the fact that the unwitnessed fall suggested the resident was at risk of further falls, neither the care plan or the kardex, identified by the RCD (Residential Care Director) as the working tool utilized by direct care staff to provide individual care, reflected the fall or included any new fall prevention interventions to reduce the risk of further falls. 2. Per record review Resident #2 was identified at high risk for falls on admission to the home. The resident, who was admitted on 4/27/15, had an unwitnessed fall at 1:00 AM on 5/7/15 and another witnessed fall later that same day. In addition, the resident sustained an additional 5 falls between 5/19/15 and 5/29/15. A progress note, on 6/3/15, indicated that discussion regarding interventions to reduce further falls had occurred, on that date, between the RCD and a resident representative, however neither the resident's care plan or kardex addressed any interventions. And, although a subsequent note, on 6/4/15 stated that a private caregiver had been secured by the resident's family to provide 1:1 observations, following another fall on the evening of 6/3/15, there were no parameters identified to determine how often or what period of time the private caregiver would be available 3. Per review of Resident #4's record s/he sustained a fall on 1/12/15 requiring transfer to the ED (Emergency Department) for evaluation	R145	Measures to be put in place or systemic changes that will be made to ensure that the practice does not recur: • Re-education provided to Nurses reviewing interventions to consider for fall prevention and intervention. • Re-orientation provided to all nurses re: The Arbors fall matrix reflecting standards and practice/policy as well as expectations regarding documentation. • Weekly Tracking Meeting has been ongoing will continue to review resident change in status or those residents identified with a high risk of falling or residents with repeated falls. Each recommended fall prevention measure will be included on the specific care plan and Kardex. • Mandatory in-service for all nurses on fall risk, interventions and documentation/ communication of resident care needs and services to staff by RCD /Designee.	6/9/15 6/9/15 Continue weekly 6/17/15 by 8/1/15	

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R145	Continued From page 2 and treatment of a head wound and a follow up note, dated 1/13/15 indicated the resident's "bed now on floor..." Further progress notes indicated that the resident also sustained unwitnessed falls on 3/15/15, 3/16/16 and 3/24/15 without injury, and a fall on 5/25/15 resulting in a minor injury to the chin. Despite the multiple falls the resident's care plan and kardex did not address the falls or include any interventions to reduce risk of further falls. During interview, on the afternoon of 6/9/15, the nurse responsible for development of resident care plans confirmed the lack of fall prevention interventions on both the care plans and kardexes for both Resident #2 and Resident #4. S/he also confirmed that no parameters had been identified for determining use of private caregivers, implemented after 6/3/15, for Resident #2, and stated s/he did not know what the plan was regarding the 1:1 caregivers.	R145	Monitoring of corrective actions: • Care plan and kardex audits will be performed by Resident Care Director or Designee for residents with multiple interventions/services in place (4 resident audits completed monthly). • Completed care plan and kardex audits will be reported Quarterly to The Quality Assessment Committee.	Ongoing Each Quarter